

2023 -- H 5426 SUBSTITUTE A

LC001423/SUB A

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2023

A N A C T

RELATING TO INSURANCE -- INDIVIDUAL HEALTH INSURANCE COVERAGE

Introduced By: Representatives Speakman, Kislak, Donovan, Ajello, Morales, Carson, Bennett, Alzate, McGaw, and McEntee

Date Introduced: February 08, 2023

Referred To: House Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Sections 27-18.5-3, 27-18.5-4, 27-18.5-5, 27-18.5-6 and 27-18.5-10 of the
2 General Laws in Chapter 27-18.5 entitled "Individual Health Insurance Coverage" are hereby
3 amended to read as follows:

4 **27-18.5-3. Guaranteed availability to certain individuals.**

5 (a) ~~Notwithstanding any of the provisions of this title to the contrary~~ Subject to subsections
6 (b) through (i) of this section, all health insurance carriers that offer health insurance coverage in
7 the individual market in this state shall provide for the guaranteed availability of coverage to ~~an~~
8 ~~eligible individual or an individual who has had health insurance coverage, including coverage in~~
9 ~~the individual market, or coverage under a group health plan or coverage under 5 U.S.C. § 8901 et~~
10 ~~seq. and had that coverage continuously for at least twelve (12) consecutive months and who~~
11 ~~applies for coverage in the individual market no later than sixty three (63) days following~~
12 ~~termination of the coverage, desiring to enroll in individual health insurance coverage, and who is~~
13 ~~not eligible for coverage under a group health plan, part A or part B or title XVIII of the Social~~
14 ~~Security Act, 42 U.S.C. § 1395c et seq. or 42 U.S.C. § 1395j et seq., or any state plan under title~~
15 ~~XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (or any successor program) and does not~~
16 ~~have other health insurance coverage (provided, that eligibility for the other coverage shall not~~
17 ~~disqualify an individual with twelve (12) months of consecutive coverage if that individual applies~~
18 ~~for coverage in the individual market for the primary purpose of obtaining coverage for a specific~~
19 ~~pre-existing condition, and the other available coverage excludes coverage for that pre-existing~~

1 ~~condition) and~~ any eligible applicant. For the purposes of this section, an "eligible applicant" means
2 any individual resident of this state. A carrier offering health insurance coverage in the individual
3 market shall offer to any eligible applicant in the state all health insurance coverage plans of that
4 carrier that are approved for sale in the individual market and shall accept any eligible applicant
5 that applies for coverage under those plans. A carrier may not:

- 6 (1) Decline to offer the coverage to, or deny enrollment of, the individual; or
- 7 (2) Impose any preexisting condition exclusion with respect to the coverage.

8 ~~(b)(4)~~ All health insurance carriers that offer health insurance coverage in the individual
9 market in this state shall offer all policy forms of health insurance coverage to all eligible
10 applicants. Provided, a carrier may offer plans with reduced cost sharing for qualifying eligible
11 applicants, based on available federal funds including those described by 42 U.S.C. § 18071, or
12 based on a program established with state funds. ~~Provided, the carrier may elect to limit the~~
13 ~~coverage offered so long as it offers at least two (2) different policy forms of health insurance~~
14 ~~coverage (policy forms which have different cost sharing arrangements or different riders shall be~~
15 ~~considered to be different policy forms) both of which:~~

16 ~~(i) Are designed for, made generally available to, and actively market to, and enroll both~~
17 ~~eligible and other individuals by the carrier; and~~

18 ~~(ii) Meet the requirements of subparagraph (A) or (B) of this paragraph as elected by the~~
19 ~~carrier:~~

20 ~~(A) If the carrier offers the policy forms with the largest, and next to the largest, premium~~
21 ~~volume of all the policy forms offered by the carrier in this state; or~~

22 ~~(B) If the carrier offers a choice of two (2) policy forms with representative coverage,~~
23 ~~consisting of a lower level coverage policy form and a higher level coverage policy form each of~~
24 ~~which includes benefits substantially similar to other individual health insurance coverage offered~~
25 ~~by the carrier in this state and each of which is covered under a method that provides for risk~~
26 ~~adjustment, risk spreading, or financial subsidization.~~

27 ~~(2) For the purposes of this subsection, "lower level coverage" means a policy form for~~
28 ~~which the actuarial value of the benefits under the coverage is at least eighty five percent (85%)~~
29 ~~but not greater than one hundred percent (100%) of the policy form weighted average.~~

30 ~~(3) For the purposes of this subsection, "higher level coverage" means a policy form for~~
31 ~~which the actuarial value of the benefits under the coverage is at least fifteen percent (15%) greater~~
32 ~~than the actuarial value of lower level coverage offered by the carrier in this state, and the actuarial~~
33 ~~value of the benefits under the coverage is at least one hundred percent (100%) but not greater than~~
34 ~~one hundred twenty percent (120%) of the policy form weighted average.~~

1 ~~(4) For the purposes of this subsection, “policy form weighted average” means the average~~
2 ~~actuarial value of the benefits provided by all the health insurance coverage issued (as elected by~~
3 ~~the carrier) either by that carrier or, if the data are available, by all carriers in this state in the~~
4 ~~individual market during the previous year (not including coverage issued under this subsection),~~
5 ~~weighted by enrollment for the different coverage. The actuarial value of benefits shall be~~
6 ~~calculated based on a standardized population and a set of standardized utilization and cost factors.~~

7 ~~(5) The carrier elections under this subsection shall apply uniformly to all eligible~~
8 ~~individuals in this state for that carrier. The election shall be effective for policies offered during a~~
9 ~~period of not shorter than two (2) years.~~

10 (c)(1) A carrier may deny health insurance coverage in the individual market to an eligible
11 ~~individual~~ applicant if the carrier has demonstrated to the ~~director~~ commissioner that:

12 (i) It does not have the financial reserves necessary to underwrite additional coverage; and

13 (ii) It is applying this subsection uniformly to all individuals in the individual market in
14 this state consistent with applicable state law and without regard to any health status-related factor
15 of the individuals ~~and without regard to whether the individuals are eligible individuals.~~

16 (2) A carrier upon denying individual health insurance coverage in this state in accordance
17 with this subsection may not offer that coverage in the individual market in this state for a period
18 of one hundred eighty (180) days after the date the coverage is denied or until the carrier has
19 demonstrated to the ~~director~~ commissioner that the carrier has sufficient financial reserves to
20 underwrite additional coverage, whichever is later.

21 (d) Nothing in this section shall be construed to require that a carrier offering health
22 insurance coverage only in connection with group health plans or through one or more bona fide
23 associations, or both, offer health insurance coverage in the individual market.

24 (e) A carrier offering health insurance coverage in connection with group health plans
25 under this title shall not be deemed to be a health insurance carrier offering individual health
26 insurance coverage solely because the carrier offers a conversion policy.

27 (f) Except for any high risk pool rating rules to be established by the Office of the Health
28 Insurance Commissioner (OHIC) as described in this section, nothing in this section shall be
29 construed to create additional restrictions on the amount of premium rates that a carrier may charge
30 an individual for health insurance coverage provided in the individual market; or to prevent a health
31 insurance carrier offering health insurance coverage in the individual market from establishing
32 premium rates or modifying applicable copayments or deductibles in return for adherence to
33 programs of health promotion and disease prevention.

34 (g) OHIC may pursue federal funding in support of the development of a high risk pool for

1 the individual market, as defined in § 27-18.5-2, contingent upon a thorough assessment of any
2 financial obligation of the state related to the receipt of said federal funding being presented to, and
3 approved by, the general assembly by passage of concurrent general assembly resolution. The
4 components of the high risk pool program, including, but not limited to, rating rules, eligibility
5 requirements and administrative processes, shall be designed in accordance with § 2745 of the
6 Public Health Service Act (42 U.S.C. § 300gg-45) also known as the State High Risk Pool Funding
7 Extension Act of 2006 and defined in regulations promulgated by the office of the health insurance
8 commissioner on or before October 1, 2007.

9 (h)(1) In the case of a health insurance carrier that offers health insurance coverage in the
10 individual market through a network plan, the carrier may limit the individuals who may be enrolled
11 under that coverage to those who live, reside, or work within the service areas for the network plan;
12 and within the service areas of the plan, deny coverage to individuals if the carrier has demonstrated
13 to the director that:

14 (i) It will not have the capacity to deliver services adequately to additional individual
15 enrollees because of its obligations to existing group contract holders and enrollees and individual
16 enrollees; and

17 (ii) It is applying this subsection uniformly to individuals without regard to any health
18 status-related factor of the individuals and without regard to whether the individuals are eligible
19 individuals.

20 (2) Upon denying health insurance coverage in any service area in accordance with the
21 terms of this subsection, a carrier may not offer coverage in the individual market within the service
22 area for a period of one hundred eighty (180) days after the coverage is denied.

23 (i) A carrier must allow an eligible applicant to enroll in coverage during:

24 (A) An open enrollment period to be established by the commissioner and held annually
25 for a period of between thirty (30) and sixty (60) days;

26 (B) Special enrollment periods as established in accordance with the version of 45 C.F.R.
27 § 147.104 in effect on January 1, 2023; and

28 (C) Any other open enrollment periods or special enrollment periods established by federal
29 or state law, rule or regulation.

30 **27-18.5-4. Continuation of coverage — Renewability.**

31 (a) A health insurance carrier that provides individual health insurance coverage to an
32 individual in this state shall renew or continue in force that coverage at the option of the individual.

33 (b) A health insurance carrier may ~~nonrenew~~ non-renew or discontinue health insurance
34 coverage of an individual in the individual market based only on one or more of the following:

1 (1) The individual has failed to pay premiums or contributions in accordance with the terms
2 of the health insurance coverage, including terms relating to ~~or the carrier has not received~~ timely
3 premium payments;

4 (2) The individual has performed an act or practice that constitutes fraud or made an
5 intentional misrepresentation of material fact under the terms of the coverage;

6 (3) The carrier is ceasing to offer coverage in accordance with subsections (c) and (d) of
7 this section;

8 (4) In the case of a carrier that offers health insurance coverage in the market through a
9 network plan, the individual no longer resides, lives, or works in the service area (or in an area for
10 which the carrier is authorized to do business) but only if the coverage is terminated uniformly
11 without regard to any health status-related factor of covered individuals; or

12 (5) In the case of health insurance coverage that is made available in the individual market
13 only through one or more bona fide associations, the membership of the individual in the
14 association (on the basis of which the coverage is provided) ceases but only if the coverage is
15 terminated uniformly and without regard to any health status-related factor of covered individuals.

16 (c) In any case in which a carrier decides to discontinue offering a particular type of health
17 insurance coverage offered in the individual market, coverage of that type may be discontinued
18 only if:

19 (1) The carrier provides notice, to each covered individual provided coverage of this type
20 in the market, of the discontinuation at least ninety (90) days prior to the date of discontinuation of
21 the coverage;

22 (2) The carrier offers to each individual in the individual market provided coverage of this
23 type, the opportunity to purchase any other individual health insurance coverage currently being
24 offered by the carrier for individuals in the market; and

25 (3) In exercising this option to discontinue coverage of this type and in offering the option
26 of coverage under subdivision (2) of this subsection, the carrier acts uniformly without regard to
27 any health status-related factor of enrolled individuals or individuals who may become eligible for
28 the coverage.

29 (d) In any case in which a carrier elects to discontinue offering all health insurance
30 coverage in the individual market in this state, health insurance coverage may be discontinued only
31 if:

32 (1) The carrier provides notice to the ~~director~~ commissioner and to each individual of the
33 discontinuation at least one hundred eighty (180) days prior to the date of the expiration of the
34 coverage; and

1 (2) All health insurance issued or delivered in this state in the market is discontinued and
2 coverage under this health insurance coverage in the market is not renewed.

3 (e) In the case of a discontinuation under subsection (d) of this section, the carrier may not
4 provide for the issuance of any health insurance coverage in the individual market in this state
5 during the five (5) year period beginning on the date the carrier filed its notice with the department
6 to withdraw from the individual health insurance market in this state. This five (5) year period may
7 be reduced to a minimum of three (3) years at the discretion of the health insurance commissioner,
8 based on his/her analysis of market conditions and other related factors.

9 (f) The provisions of subsections (d) and (e) of this section do not apply if, at the time of
10 coverage renewal, a health insurance carrier modifies the health insurance coverage for a policy
11 form offered to individuals in the individual market so long as the modification is consistent with
12 this chapter and other applicable law and effective on a uniform basis among all individuals with
13 that policy form.

14 (g) In applying this section in the case of health insurance coverage made available by a
15 carrier in the individual market to individuals only through one or more associations, a reference
16 to an “individual” includes a reference to the association (of which the individual is a member).

17 **27-18.5-5. Enforcement — Limitation on actions.**

18 The ~~director~~ [commissioner](#) has the power to enforce the provisions of this chapter in
19 accordance with § 42-14-16 and all other applicable laws.

20 **27-18.5-6. Rules and regulations.**

21 The ~~director~~ [commissioner](#) may promulgate rules and regulations necessary to effectuate
22 the purposes of this chapter.

23 **27-18.5-10. Prohibition on preexisting condition exclusions.**

24 (a) A health insurance policy, subscriber contract, or health plan offered, issued, issued for
25 delivery, or issued to cover a resident of this state by a health insurance company licensed pursuant
26 to this title and/or chapter: shall not limit or exclude coverage for any individual by imposing a
27 preexisting condition exclusion on that individual.

28 ~~(1) Shall not limit or exclude coverage for an individual under the age of nineteen (19) by~~
29 ~~imposing a preexisting condition exclusion on that individual.~~

30 ~~(2) For plan or policy years beginning on or after January 1, 2014, shall not limit or exclude~~
31 ~~coverage for any individual by imposing a preexisting condition exclusion on that individual.~~

32 (b) As used in this section: ~~(1) “Preexisting~~ [preexisting](#) condition exclusion” ~~means a~~
33 ~~limitation or exclusion of benefits, including a denial of coverage, based on the fact that the~~
34 ~~condition (whether physical or mental) was present before the effective date of coverage, or if the~~

~~coverage is denied, the date of denial, under a health benefit plan whether or not any medical advice, diagnosis, care or treatment was recommended or received before the effective date of coverage.~~

~~(2) "Preexisting condition exclusion"~~ means any limitation or exclusion of benefits, including a denial of coverage, applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage, or if the coverage is denied, the date of denial, under the health benefit plan, such as a condition (whether physical or mental) identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

(c) This section shall not apply to grandfathered health plans providing individual health insurance coverage.

(d) This section shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by accident or both; and (9) Other limited benefit policies.

SECTION 2. Chapter 27-18.5 of the General Laws entitled "Individual Health Insurance Coverage" is hereby amended by adding thereto the following section:

27-18.5-11. Essential health benefits -- Individual.

(a) The following words and phrases as used in this section have the following meanings consistent with federal law and regulations adopted thereunder, as long as they remain in effect. If such authorities are determined by the commissioner to no longer be in effect, the laws and regulations in effect as of the date immediately prior to their legislative repeal or their being declared invalid or nullified by final federal judicial or executive branch action, as identified by the commissioner shall govern, unless a different meaning is required by the context:

(1) "Essential health benefits" means the following general categories, and the services covered within those categories as defined pursuant to the processes described in 42 U.S.C. § 18022 and implementing regulations and guidance:

(i) Ambulatory patient services;

(ii) Emergency services;

(iii) Hospitalization;

(iv) Maternity and newborn care;

(v) Mental health and substance use disorder services, including behavioral health treatment;

(vi) Prescription drugs;

(vii) Rehabilitative and habilitative services and devices;

- 1 (viii) Laboratory services;
2 (ix) Preventive services, wellness services, and chronic disease management; and
3 (x) Pediatric services, including oral and vision care.

4 (2) "Preventive services" means those services described in 42 U.S.C. § 300gg-13 and
5 implementing regulations and guidance.

6 (b) If any provision of the federal Patient Protection and Affordable Care Act and
7 implementing regulations relating to coverage for essential health benefits and/or for preventive
8 services without cost sharing are determined by the commissioner to have been repealed or to have
9 been declared invalid or nullified by the final judgment of a federal court applicable to the state or
10 by executive or administrative action, which shall be deemed to include an action of the federal
11 executive or judicial branch that nullifies the effectiveness of the obligation to provide coverage
12 without cost sharing for a meaningful range of preventive services substantially similar to those
13 preventive services required under 42 U.S.C. § 300gg-13 as of January 1, 2023, then the following
14 shall apply:

15 (1) A health insurance policy, subscriber contract, or health plan offered, issued, renewed,
16 issued for delivery, or issued to cover a resident of this state, by a health insurance company
17 licensed pursuant to this title and/or chapter shall provide coverage of at least the essential health
18 benefits categories set forth in this section, and shall further provide coverage of preventive services
19 from in-network providers without applying any copayments, deductibles, coinsurance, or other
20 cost sharing, as described in 42 U.S.C. § 300gg-13 and related regulations and guidance, including
21 existing exemptions, in effect as of the date immediately prior to their repeal, revocation, or
22 nullification, as set forth above.

23 (2) To the extent that the U.S. Preventive Services Taskforce revises its recommendations
24 with respect to grade "A" or "B" preventive services, or other expert advisory panel designated in
25 42 U.S.C. § 300gg-13 similarly provides new or revised recommendations, the office of the health
26 insurance commissioner shall have the authority to issue guidance clarifying the services that shall
27 qualify as preventive services under this section, consistent with said recommendations and in
28 accordance with the processes as had been described by the version of 42 U.S.C. § 300gg-13(b)
29 and related regulations and guidance in effect as of the date immediately prior to their repeal,
30 revocation, or nullification, as set forth above.

31 (c) If a health insurance policy, subscriber contract, or health plan offered, issued, renewed,
32 issued for delivery, or issued to cover a resident of this state, by a health insurance company
33 licensed pursuant to this title and/or chapter, was not subject to the requirements described in
34 subsection (b) of this section prior to their repeal, revocation, or nullification, then such policy,

1 contract, or plan shall remain so exempt and the provisions of this section shall not apply.

2 SECTION 3. Chapter 27-18.6 of the General Laws entitled "Large Group Health Insurance
3 Coverage" is hereby amended by adding thereto the following section:

4 **27-18.6-3.2. Preventative services.**

5 (a) As used in this section, "preventive services" means those services described in 42
6 U.S.C. § 300gg-13 and implementing regulations and guidance.

7 (b) If any provision of the federal Patient Protection and Affordable Care Act and
8 implementing regulations relating to preventive services without cost sharing are determined by
9 the commissioner to have been repealed or to have been declared invalid or nullified by the final
10 judgment of a federal court applicable to the state or by executive or administrative action, which
11 shall be deemed to include an action of the executive or judicial branch that nullifies the
12 effectiveness of the obligation to provide coverage without cost sharing for a meaningful range of
13 preventive services substantially similar to those in effect as of January 1, 2023, then the following
14 shall apply:

15 (1) A health insurance policy, subscriber contract, or health plan offered, issued, renewed,
16 issued for delivery, or issued to cover a resident of this state, by a health insurance company
17 licensed pursuant to this title and/or chapter, shall provide coverage of preventive services from in-
18 network providers without applying any copayments, deductibles, coinsurance, or other cost
19 sharing, as described in 42 U.S.C. § 300gg-13 and related regulations and guidance, including
20 existing exemptions, in effect as of the date immediately prior to their repeal, revocation, or
21 nullification, as set forth above.

22 (2) To the extent that the U.S. Preventive Services Taskforce revises its recommendations
23 with respect to grade "A" or "B" preventive services or other expert advisory panel described in 42
24 U.S.C. § 300gg-13, similarly provides new or revised recommendations the office of the health
25 insurance commissioner shall have the authority to issue guidance clarifying the services that shall
26 qualify as preventive services under this section, consistent with said recommendations, and in
27 accordance with the process as had been described by the version of 42 U.S.C. § 300gg-13(b) and
28 related regulations and guidance in effect as of the date immediately prior to their repeal,
29 revocation, or nullification, as set forth above.

30 (c) If a health insurance policy, subscriber contract, or health plan offered, issued, renewed,
31 issued for delivery, or issued to cover a resident of this state, by a health insurance company
32 licensed pursuant to this title and/or chapter, was not subject to the requirements described in
33 subsection (b) of this section prior to their repeal, revocation, or nullification, then such policy,
34 contract, or plan shall remain so exempt and the provisions of this section shall not apply.

1 SECTION 4. Section 27-50-11 of the General Laws in Chapter 27-50 entitled "Small
2 Employer Health Insurance Availability Act" is hereby amended to read as follows:

3 **27-50-11. Administrative procedures.**

4 The ~~director shall issue~~ commissioner may promulgate rules and regulations necessary to
5 effectuate the purposes of this chapter ~~in accordance with chapter 35 of this title for the~~
6 ~~implementation and administration of the Small Employer Health Insurance Availability Act.~~

7 SECTION 5. Chapter 27-50 of the General Laws entitled "Small Employer Health
8 Insurance Availability Act" is hereby amended by adding thereto the following section:

9 **27-50-19. Essential health benefits.**

10 (a) The following words and phrases as used in this section have the following meanings
11 consistent with federal law and regulations adopted thereunder, as long as they remain in effect. If
12 such authorities are determined by the commissioner to no longer be in effect, the laws and
13 regulations in effect as of the date immediately prior to their legislative repeal or their being
14 declared invalid or nullified by federal judicial or executive branch action, as identified by the
15 commissioner shall govern, unless a different meaning is required by the context:

16 (1) "Essential health benefits" means the following general categories, and the services
17 covered within those categories as defined pursuant to the processes described in 42 U.S.C. § 18022
18 and implementing regulations and guidance:

19 (i) Ambulatory patient services;

20 (ii) Emergency services;

21 (iii) Hospitalization;

22 (iv) Maternity and newborn care;

23 (v) Mental health and substance use disorder services, including behavioral health
24 treatment;

25 (vi) Prescription drugs;

26 (vii) Rehabilitative and habilitative services and devices;

27 (viii) Laboratory services;

28 (ix) Preventive services, wellness services, and chronic disease management; and

29 (x) Pediatric services, including oral and vision care.

30 (2) "Preventative services" means those services described in 42 U.S.C. § 300gg-13 and
31 implementing regulations and guidance.

32 (b) If any provision of the federal Patient Protection and Affordable Care Act and
33 implementing regulations relating to coverage for essential health benefits and/or for preventive
34 services without cost sharing are determined by the commissioner to have been repealed or to have

1 been declared invalid or nullified by the final judgment of a federal judicial branch applicable to
2 the state or by executive or administrative action, which shall be deemed to include an action of the
3 federal executive or judicial branch that nullifies the effectiveness of the obligation to provide
4 coverage without cost sharing for a meaningful range of preventive services substantially similar
5 to those preventive services required under 42 U.S.C. § 300gg-13 as of January 1, 2023, then the
6 following shall apply:

7 (1) A health insurance policy, subscriber contract, or health plan offered, issued, renewed,
8 issued for delivery, or issued to cover a resident of this state, by a health insurance company
9 licensed pursuant to this title and/or chapter shall provide coverage of at least the essential health
10 benefits categories set forth in this section, and shall further provide coverage of preventive services
11 from in-network providers without applying any copayments, deductibles, coinsurance, or other
12 cost sharing, as described in 42 U.S.C. § 300gg-13 and related regulations and guidance, including
13 existing exemptions, in effect as of the date immediately prior to their repeal, revocation, or
14 nullification, as set forth above.

15 (2) To the extent that the U.S. Preventive Services Taskforce revises its recommendations
16 with respect to grade "A" or "B" preventive services, or other expert advisory panel designated in
17 42 U.S.C. § 300gg-13 similarly provides new or revised recommendations, the office of health
18 insurance commissioner shall have the authority to issue guidance clarifying the services that shall
19 qualify as preventive services under this section, consistent with said recommendations and in
20 accordance with the processes as had been described by the version of 42 U.S.C. § 300gg-13(b)
21 and related regulations and guidance in effect as of the date immediately prior to their repeal,
22 revocation, or nullification, as set forth above.

23 (c) If a health insurance policy, subscriber contract, or health plan offered, issued, renewed,
24 issued for delivery, or issued to cover a resident of this state, by a health insurance company
25 licensed pursuant to this title and/or chapter, was not subject to the requirements described in
26 subsection (b) of this section prior to their repeal, revocation, or nullification, then such policy,
27 contract, or plan shall remain so exempt and the provisions of this section shall not apply.

28 SECTION 6. Chapter 42-14.5 of the General Laws entitled "The Rhode Island Health Care
29 Reform Act of 2004 — Health Insurance Oversight" is hereby amended by adding thereto the
30 following section:

31 **42-14.5-3.1. Reporting changes in federal law.**

32 If any provision of the federal Patient Protection and Affordable Care Act and/or its
33 implementing regulations relating to coverage for essential health benefits or preventive services
34 are determined by the commissioner to have been repealed or to have been declared invalid or

1 nullified by the final judgment of a federal court applicable to the state or by executive or
2 administrative action, which shall be deemed to include an action of the executive or judicial branch
3 that nullifies the effectiveness of the provision, such that the commissioner intends to take action
4 pursuant to the authority conferred on him or her pursuant to the authority granted by §§ 27-18.5-
5 11, 27-18.6-3.2, or 27-50-18, the commissioner shall report to the general assembly as soon as
6 possible to describe the impact of the change and to make recommendations regarding consumer
7 protections, consumer choices, and stabilization and affordability of the Rhode Island insurance
8 market.

9 SECTION 7. This act shall take effect upon passage.

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LC001423/SUB A
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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF
A N A C T
RELATING TO INSURANCE -- INDIVIDUAL HEALTH INSURANCE COVERAGE

1 This act would provide guaranteed availability of coverage to any eligible individual
2 resident of this state. Coverage could not be limited or excluded by imposing a preexisting
3 condition exclusion. It would also require individual health insurers, large group health insurers
4 and small employer health insurers to provide coverage for ten (10) categories of essential health
5 benefits listed in the act.

6 This act would take effect upon passage.

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LC001423/SUB A
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